Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

DATE NOTICE SENT TO ALL PARTIES: Oct/26/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar Sympathetic Ganglion nerve block @L2, L4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that the proposed Lumbar Sympathetic Ganglion nerve block @L2, L4 would not be considered medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX when he sustained a xxxx. The patient has been followed for persistent pain involving the left lower extremity in the residual limb following the injury. The patient has also been followed for complaints of neck pain. Prior medications have included the use of Gabapentin as well as Norco. The patient had recently been followed. The updated xxxx evaluation still noted pain in the low back, bilateral hips, and bilateral knees with increasing phantom pain involving the left lower extremity. The patient indicated that his phantom limb pain could become severe at times. The physical examination noted painful range of motion of the left knee. There were pain behaviors present. No specific dermatomal findings were noted. There was limited range of motion in the lumbar spine. The patient was still being recommended for lumbar sympathetic nerve blocks.

The lumbar sympathetic block was denied by utilization review on xxxxx as there were minimal findings to support a diagnosis of reflex sympathetic dystrophy. It was also unclear what conservative treatment had been exhausted prior to the requested lumbar sympathetic block. It was also unclear whether the block would be utilized in addition to aggressive physical therapy as recommended by guidelines. There was a utilization report dated xxxxx; however, this addressed prosthetic liners.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation submitted for review did not address the initial denial regarding a lumbar sympathetic block. The most recent evaluation did not clearly identify findings consistent with reflex sympathetic dystrophy involving the left lower extremity. Although the patient's symptoms had persisted despite the use of Gabapentin, it is unclear what other conservative efforts have been exhausted to date to address the patient's phantom leg symptoms. The most recent clinical records also did not discuss any consideration for aggressive physical therapy to be utilized in conjunction with the requested block. As the clinical documentation submitted for review did not meet

guideline recommendations regarding the request, it is this reviewer's opinion that the proposed Lumbar Sympathetic Ganglion nerve block @L2, L4 would not be considered medically necessary and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)